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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the medical director or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11418
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11404
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 2 Mi. W. Red House Mins.		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia		b. COUNTY Fairfax		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 2001 North Uhl St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgelon		First		Middle		Last		4. DATE OF DEATH Oct. 22 19 61		Month		Day		Year	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1941		9. AGE (In years last birthday) 19 20		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Kempton, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edgel Ford WILSON				14. MOTHER'S MAIDEN NAME Marie Hilton				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Marie Welton, Kempton, Md.				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fractured Mandible (c) Fractured Mandible												INTERVAL BETWEEN ONSET AND DEATH Mins. Mins.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident Rt. 50 Nr. Red House. Husb. operator.											
20c. TIME OF INJURY Month, Day, Year 10-22 19 61 Hour a.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway				20f. (City or town) Rural Red House Garr. Md. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE James H. Feaster, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				DATE SIGNED 10-22-61				Address (Street, city, town, or county) Oak., Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/25, 1961				22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.				22d. LOCATION (City, town, or country) (State) Thomas, W. Va.			
23. FUNERAL DIRECTOR J. H. Duncan				ADDRESS Thomas, W. Va.				24a. REC'D BY REGISTRAR OCT 25 '61				24b. REGISTRAR'S SIGNATURE Chas. S. Kins			

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(IV)

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ma retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11419

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11405

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gorman		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marcellus Middle S. Last Arnold		4. DATE OF DEATH Month Oct. Day 28, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1877
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 8 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Washington Arnold		14. MOTHER'S MAIDEN NAME Catherine Wolfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 236-44-7054	
17. INFORMANT Mrs. Katie Henline Gormanian, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial hypertrophy & failure DUE TO (c) Arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 3 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 28 1949 to OCTOBER 28 19 61 . that (I) (we) last saw the deceased alive on 10/15/ 19 61 and that death occurred at 8:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE A. E. Mance		22b. DATE SIGNED 29 Oct 61	
22c. PHYSICIAN'S NAME (Type) A. E. MANCE, M.D.		22d. ADDRESS 101 THIRD ST., OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 31, 61	
23c. NAME OF CEMETERY OR CREMATORY Eglon		23d. LOCATION (City, town, or county) (State) Eglon W.Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Biggs		25a. REC'D BY REGISTRAR DATE NOV 3 '61	
ADDRESS Davis, W.Va.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11420

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11406

1. PLACE OF DEATH a. COUNTY Garrett				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Addie Myrtle Ashby				4. DATE OF DEATH Month Day Year October 10 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 3, 1889	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Tucker County, W. Va.	
12. CITIZEN OF WHAT COUNTRY? United States				13. FATHER'S NAME Peter Adams			
14. MOTHER'S MAIDEN NAME Sarah E. Roy				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Stanley Ashby, Crellin, Md. (husband)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver 153-8 DUE TO (b) Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from July 19 50 to October 10, 1961 , that (I) (we) last saw the deceased alive on October 10 19 61 , and that death occurred at 1:25p from the causes and on the date stated above. 22a. SIGNATURE E. I. Baumgartner, M. D. 22b. DATE SIGNED 10/12/61 22c. PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. 22d. ADDRESS Oakland, Maryland				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/61		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City, town or county) (State) Oakland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich ADDRESS Oakland, Maryland				25a. REC'D BY REGISTRAR OCT 16 61 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11421

CERTIFICATE OF DEATH

Reg. Dist. No. 11407

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kitzmiller</u>		LENGTH OF STAY (in this place) <u>55yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kitzmiller</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>				STREET ADDRESS (If rural give location) <u>Main Street</u>			
3. NAME OF DECEASED (Type or Print) <u>IDA</u> (First) <u>BELLE</u> (Middle) <u>BARRICK</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 11, 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 13, 1874</u>		9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Preston Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Garner</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Ellen Mosser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-26-1739</u>		17. INFORMANT & ADDRESS <u>Arlie Barrick, Kitzmiller, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>420.1 Acute Coronary Thrombosis</u>						<u>Dead on arrival</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Oct 11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>61</u> , and that death occurred at <u>12:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Melph Calabrese</u>				ADDRESS (Street, city, town, state) <u>M.D. Kitzmiller, Md.</u>		DATE SIGNED <u>Oct 12-61</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 14/61</u>		NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elk Garden, Mineral Co. W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Amy M. Sharpless</u>		ADDRESS <u>Blaine, W. Va.</u>	
DATE <u>OCT 16 '61</u>							

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11422

CERTIFICATE OF DEATH

Reg. Dist. No.

11408

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND		COUNTY GARRETT			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN KITZMILLER		LENGTH OF STAY (in this place) 50yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER			
HOSPITAL OR INSTITUTION OR STREET ADDRESS WILLOW STREET				STREET ADDRESS (If rural give location) WILLOW STREET			
3. NAME OF DECEASED (Type or Print) LAURA VIRGINIA BELL				4. DATE OF DEATH (Month) (Day) (Year) OCT. 15, 1961			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 24, 1877	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIMON PETER COPLEN				14. MOTHER'S MAIDEN NAME SUSAN E. SHARPLESS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or such.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Roy Robison, Elk Garden, W. Va.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
493X IMMEDIATE CAUSE (A) Acute Myocardial Infarction						4 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral hemorrhage with rt. sided paralysis						1 week	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension						5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1953 , to Oct. 15, 1961 , that I last saw the deceased alive on Oct. 14, 1961 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above.							
SIGNATURE Ralph Calandrelli				ADDRESS (Street, city, town, state) Kitzmillers, Md.			
DATE SIGNED Oct. 16-61							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 17/61		NAME OF CEMETERY OR CREMATORY Philos Cemetery		LOCATION (City, town, or county) (State) Westernport, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Charles S. Thomas		25. FUNERAL DIRECTOR'S SIGNATURE Amy M. Sharpless		ADDRESS Blaine, W. Va.	
DATE OCT 17 '61							

CERTIFICATE OF DEATH

1922

1. Name of deceased (Print or write full name)

DATE OF DEATH
PLACE OF DEATH

2. Age (Years and months)

3. Sex (Male or Female)

4. Race (Print or write race)

5. Birth date (Month, day, year)

6. Birth place (Print or write place)

7. Cause of death (Print or write cause)

8. Date of death (Month, day, year)

9. Signature of physician (Print or write name)

10. Signature of registrar (Print or write name)

11. Signature of informant (Print or write name)

12. Signature of witness (Print or write name)

13. Signature of witness (Print or write name)

14. Signature of witness (Print or write name)

15. Signature of witness (Print or write name)

16. Signature of witness (Print or write name)

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50. Signature of witness (Print or write name)

51. Signature of witness (Print or write name)

52. Signature of witness (Print or write name)

RECEIVED

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in by the funeral director, pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

11423

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11409

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		X Accident	
3. NAME OF DECEASED (Type or print) First Mary Middle Martha Last Bittinger				4. DATE OF DEATH Month October Day 10 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1892	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Jennings, Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Thomas Gilpen				14. MOTHER'S MAIDEN NAME Mary Jane Fletcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Olive V. Glatfelter, Accident, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Accident due to falling DUE TO (b) falling Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to October 10, 1961 , that (I) (we) last saw the deceased alive on 19 and that death occurred at 8:28a , from the causes and on the date stated above.							
22a. SIGNATURE A. E. Mance, M. D.				22b. DATE SIGNED 10/10/61			
22c. PHYSICIAN'S NAME (Type) A. E. Mance, M. D.				22d. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/61		23c. NAME OF CEMETERY OR CREMATORY Rhodes Cemetery		23d. LOCATION (City, town, or county) (State) Garrett Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald M. Minnich				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE OCT 16 '61	
				25b. REGISTRAR'S SIGNATURE Charles S. Turner			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11410

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 2, Frostburg</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 2, Frostburg</u> d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>M.</u> Last <u>Caton</u>		4. DATE DEATH <u>October 12th, 1961</u> 9. AGE (In years) <u>37</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12th, 1924</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Clark</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____		14. MOTHER'S MAIDEN NAME <u>Anna P. Burdock</u> 16. SOCIAL SECURITY NO. <u>214-34-1549</u> 17. INFORMANT <u>Marshall Caton, RD 2, Frostburg, Md.</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Leukemia Acute Myeloid</u> (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY: Month, Day, Year <u>19</u> 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>30 Jan, 1961</u> to <u>10 Oct, 1961</u> that (I) (we) last saw the deceased alive on <u>11 Oct, 1961</u> , and that death occurred at _____ M, from the causes and on the date stated above. 22a. SIGNATURE <u>F. B. Whitworth</u> M.D. 22b. DATE SIGNED _____ 22c. PHYSICIAN'S NAME (Type) <u>F. B. Whitworth</u> 22d. ADDRESS <u>123 Bedford St., Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10-14-61</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Burst</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fintel Cemetery</u> ADDRESS <u>Frostburg, Md.</u> 23d. LOCATION (City, town or county) <u>RD 2, Frostburg, Md.</u> (State) _____ 25a. REC'D BY REGISTRAR <u>Oct 16 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

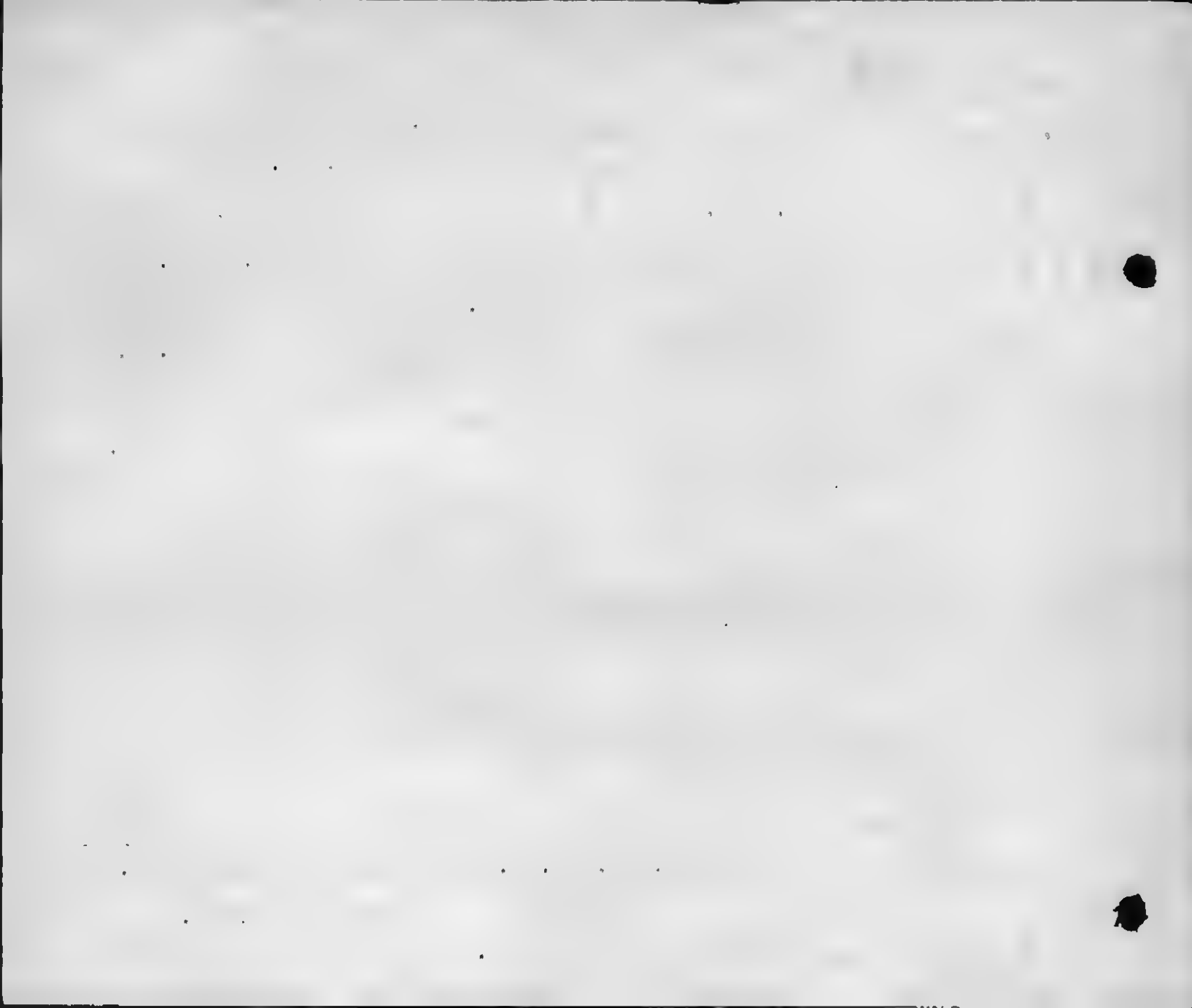


MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

Sudden

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒



VS. A15ME
SM 9/60'



1

11427

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11413

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton c. LENGTH OF STAY IN 1b 80 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION one mile West of Swanton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton d. STREET ADDRESS one mile West of Swanton e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milfred Middle Charles Last Glass		4. DATE OF DEATH Month October Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1877
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 4 Hours 1 Min 0	11. IF UNDER 24 HRS Hours 1 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Glass		14. MOTHER'S MAIDEN NAME Caroline Sweitzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Helen Winters		Address Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 602X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Thrombophlebitis of left leg DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1957 to Oct 29, 1961 , that (I) (we) last saw the deceased alive on Oct 28, 1961 , and that death occurred at 1:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Ralph Calandrella		22b. DATE SIGNED Nov. 1 - 61	
22c. PHYSICIAN'S NAME (Type) Ralph Calandrella, M. D.		22d. ADDRESS Kitzmillers, Maryland.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11/1/1961	23c. NAME OF CEMETERY OR CREMATORY George Cemetery	23d. LOCATION (City, town, or county) (State) near Swanton, Md.
24. FUNERAL DIRECTOR'S SIGNATURE H. L. Lefebvre		25a. REC'D BY REGISTRAR DATE NOV 6 '61	
ADDRESS Oakland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

B.P.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

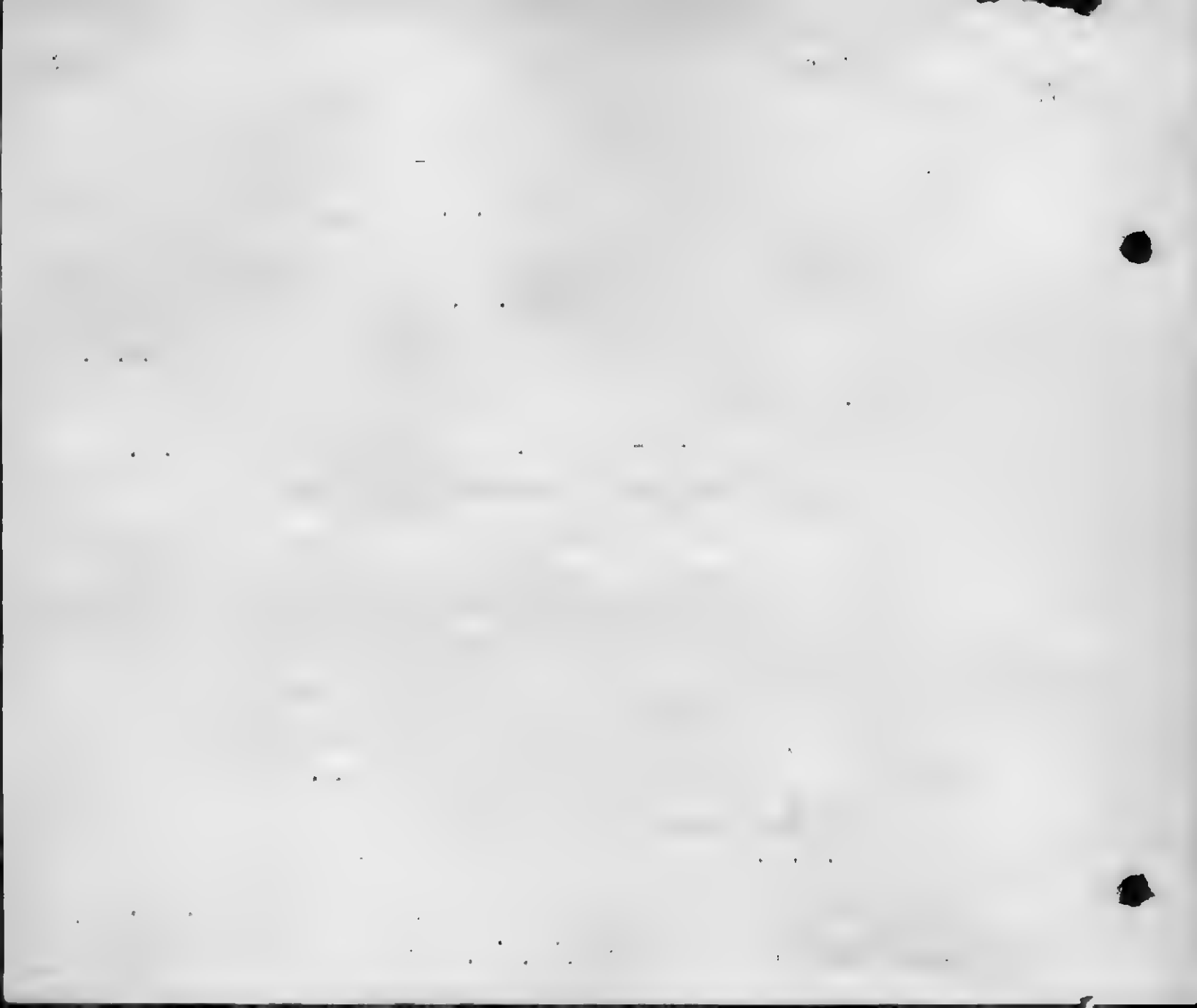
CERTIFICATE OF DEATH

11428

1414

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN 1b 18 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institutions Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - ELK GARDEN d. STREET ADDRESS R. D. # 1 BOX 222 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT PIERCE KITZMILLER		4. DATE OF DEATH OCTOBER 20 19 61	
5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH NOV. 16, 1897 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER 11. KIND OF BUSINESS OR INDUSTRY SOFT COAL 12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME ULYSSES G. KITZMILLER		14. MOTHER'S MAIDEN NAME SCHWIMMART	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 220-10-0435 17. INFORMANT MRS. DASSIE BURTON CLARKSBURG, W. VA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myeloid Lymphocytic Leukemia DUE TO (b) 204.2 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 204.2 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Where Not Where at work at work <input type="checkbox"/>	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from... 10/2/61 to... 10/20/61 , 19... that (I) (we) last saw the deceased alive on... 10/20/61 19... and that death occurred at 1:15 A.M. the causes and on the date stated above.	
22a. SIGNATURE A. E. Mance 22c. PHYSICIAN'S NAME (Type) DR. A. E. MANCE		22b. DATE SIGNED 10/26/61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/1961	
23c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery		23d. LOCATION (City, town or county) (State) Elk Garden, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Mildred Sharpless		25a. REC'D BY REGISTRAR OCT 26 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11429

11415

1 PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				e. STREET ADDRESS <u>Pennington Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Bess</u> Middle <u>Littman</u> Last <u>Lawton</u>				4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Swanton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Louis Littman</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Taggart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Arthur Lawton, Jr. (son)</u> Address <u>Oakland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary arterio-sclerosis</u> DUE TO <u>arterio-sclerosis</u> (c) <u>arterio-sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>5</u> <u>10 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>February 14, 1946</u> to <u>October 3, 1961</u> , that (I) (we) lost saw the deceased alive on <u>October 3, 1961</u> , and that death occurred at <u> </u> from the causes and on the date stated above							
22a. SIGNATURE <u>A. E. Mance</u>				22b. DATE SIGNED <u>4/16/61</u>		22c. PHYSICIAN'S NAME (Type) <u>A. E. Mance, M. D.</u>	
22d. ADDRESS <u>Oakland, Maryland</u>				22e. REC'D BY REGISTRAR <u> </u>			
23a. BURIAL CREMATON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City town, or county) (State) <u>Oakland Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald N. Minnich</u>				ADDRESS <u>Oakland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 9 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>			

October 3 1961
Revised by J. H. H. H. H.

October 3 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

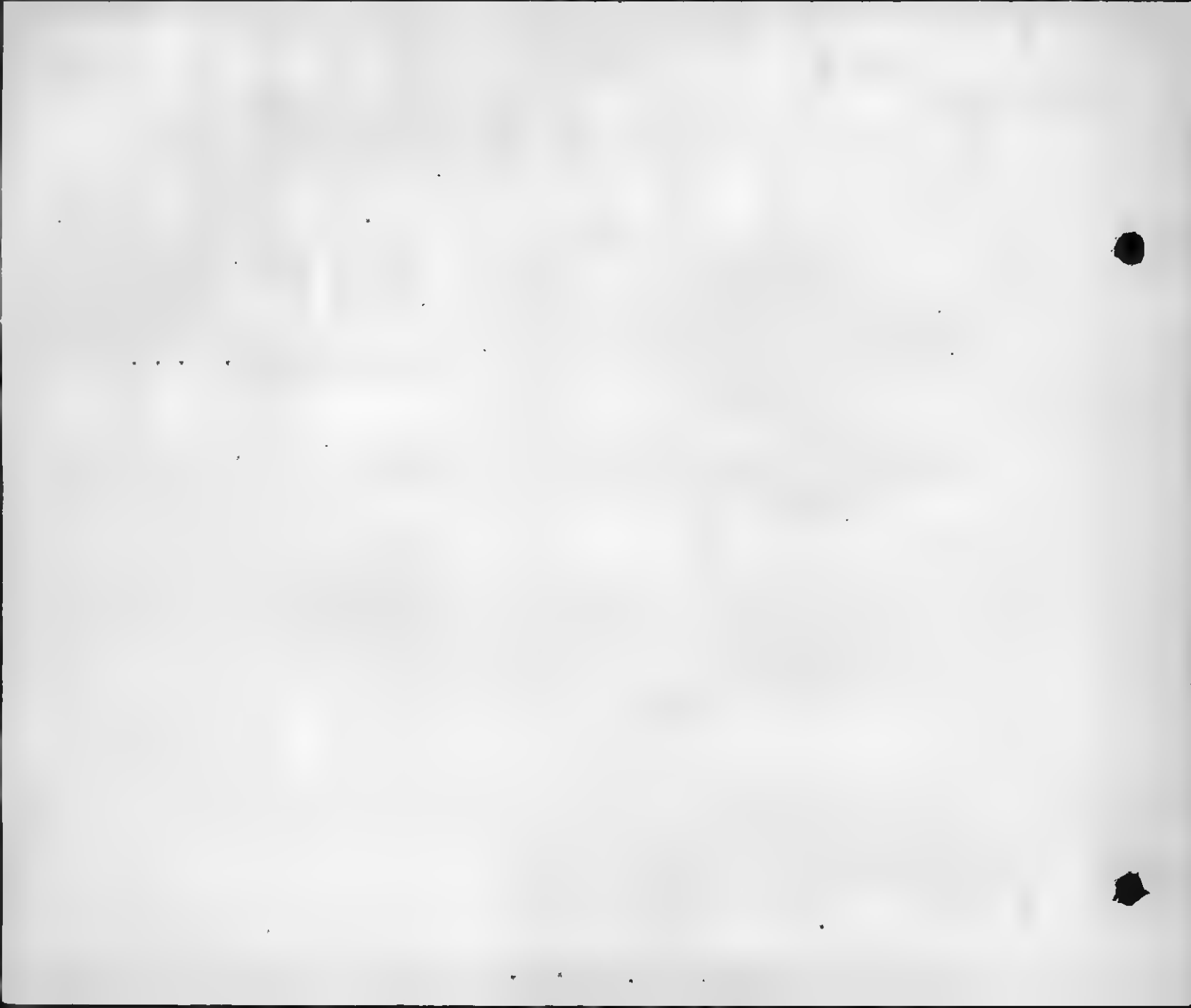
Items 13 & 14 Film G297 10/20/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 11416

11430

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b Weeks Nursing Home d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 49 Marion St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearl Middle Leslie Last 4. DATE OF DEATH Month October 11 Day 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 14, 1887 9. AGE (In years last birthday) 74 yrs IF UNDER 1 YEAR Months 7 Days 11 Hours 11 Min 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY White Sulphur Springs, Va. 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown Reynolds 14. MOTHER'S MAIDEN NAME unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO Goldie Nazelrod, Cumberland, Maryland 17. INFORMANT Goldie Nazelrod, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastritis, Peri-Renal Abscess 19. INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr. years		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-10 , 19 60 , to 10-11 , 19 61 , that I last saw the deceased alive on 10-11 , 19 61 , and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2nd St. OAKLAND, Md DATE SIGNED 10-11-61 ACTUAL SIGNATURE James H. Feaster, Jr. PHYSICIAN'S NAME (Type) James H. Feaster, Jr. M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Oct. 14, 1961 22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Jr. ADDRESS 117 Frederick St. Cumb. Md. 24a. REC'D BY REGISTRAR Oct 12 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 2646

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Friendsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Friendsville MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>Michaels</u> Last <u>Michaels</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harvey Michaels</u>		Address <u>Friendsville, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>CARDIOVASCULAR FAILURE</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>Sept</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept</u> , 19 <u>61</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Pedro Rivera</u>		ADDRESS (Street, city or town, state) <u>Friendsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>PEDRO RIVERA MD</u>		DATE SIGNED <u>10-10-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Oct 11 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>San Spring Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Friendsville, Garrett MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Newman, Grantsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 15 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by a physician or a funeral director. Page 1, 2, and 3 to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

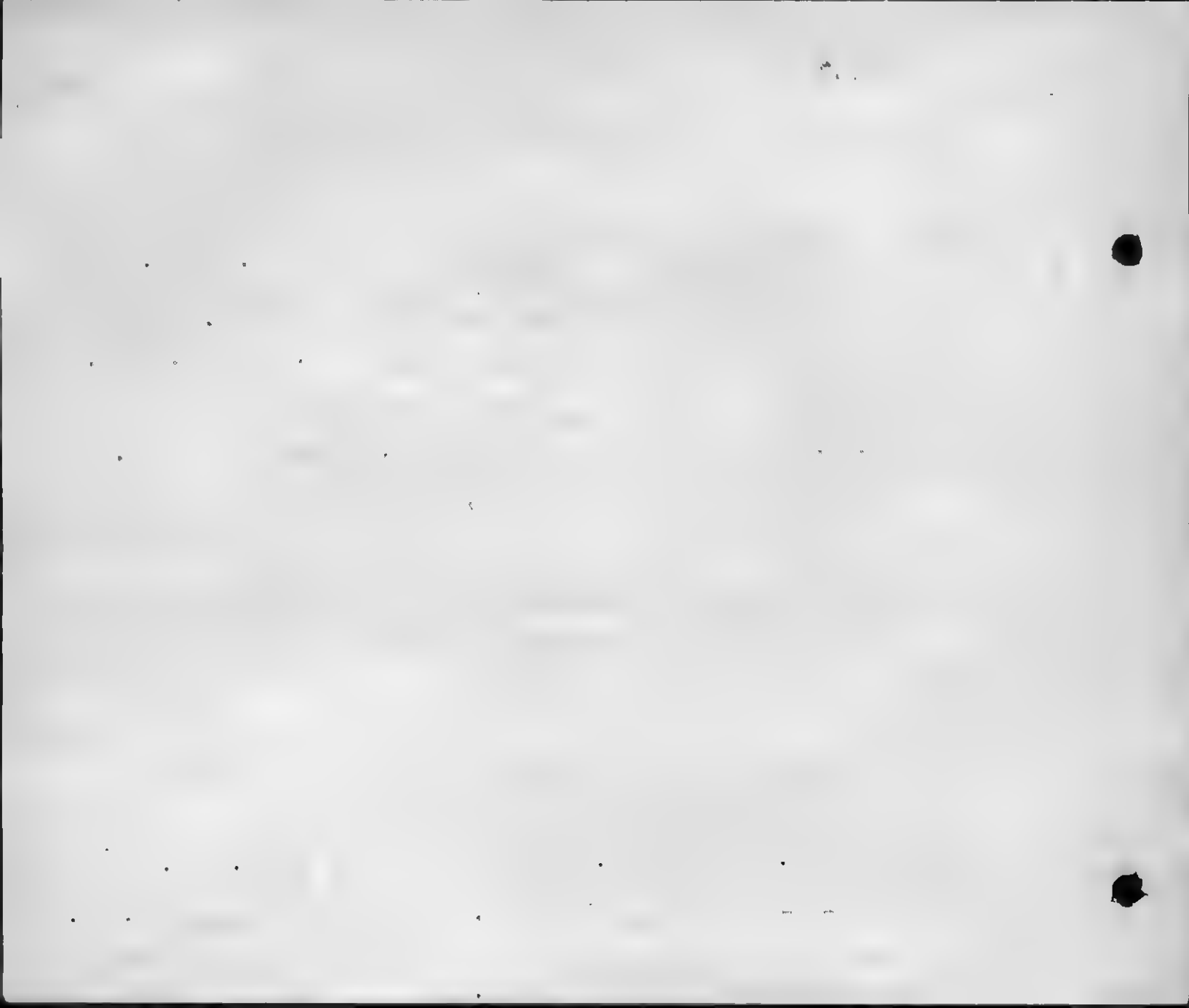
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11417

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> ✓		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>			c. LENGTH OF STAY IN lb <u>Life</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>		
d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Conrad Miller</u>			4. DATE OF DEATH Month Day Year <u>Oct. 18th. 1961</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1908</u> <u>Oct. 7 1908</u>		
9. AGE (In years last birthday) <u>53 1/2</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner Mines</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Grantsville, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Wilson E. Miller</u>			14. MOTHER'S MAIDEN NAME <u>Lydia Wissaman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W. W. II</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Ivan Miller, Grantsville, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage, massive, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Tuberculosis</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <u>10-18-61</u>					
Address (Street, city, town, or county) <u>Oak., Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville, Md.</u>	
22d. LOCATION (City, town, or country) <u>Grantsville, Garr. Md.</u>		(State)			
23. FUNERAL DIRECTOR Name (Type) <u>James H. Feaster, Jr., M. D.</u> Address <u>Grantsville, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>OCT 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11433

11418

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland,				c. LENGTH OF STAY IN 1b 60 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #2 near Gortner, Md.				e. STREET ADDRESS R. D. #2, near Gortner, Md.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jacob Middle J. Last Petersheim				4. DATE OF DEATH Month October Day 5 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1892	
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 		11. IF UNDER 24 HRS Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jonas C. Petersheim				14. MOTHER'S MAIDEN NAME Barbara Schlabach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT John Petersheim R.D.#2, Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chemia 350X DUE TO Parkinson's Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 1 week 4 Year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to Oct 5 , 19 61 , that (I) (we) lost the deceased alive on Sept , 19 61 , and that death occurred at 1:15 P M, from the causes and on the date stated above.							
22a. SIGNATURE Herbert H. Leighton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6 Oct 61	
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.				22d. ADDRESS Oakland, Maryland.			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/1961		23c. NAME OF CEMETERY OR CREMATORY Slabaugh Cemetery		23d. LOCATION (City, town, or county) (State) Garrett County near Gortner, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE OCT 9 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11419

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin, Pa.	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS 739 Main St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Goodwill Mennonite Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE W. TIPTON		4. DATE OF DEATH October 10 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soft drink bottler & distributor		10b. KIND OF BUSINESS OR INDUSTRY Somerset Co., Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Tipton		14. MOTHER'S MAIDEN NAME Emma Reitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 180-28-0041	
INFORMANT Leland Tipton, 603 Div. St., Berlin, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Oct. 3 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 3 1961 to Oct. 10 1961 that I last saw the deceased alive on Oct. 9 1961 and that death occurred at 1:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Paige Strong M.D.		DATE SIGNED Oct. 10, 1961	
PHYSICIAN'S NAME (Type) A. Paige Strong		ADDRESS (Street, city or town, state) Grantsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-13-61	
22c. NAME OF CEMETERY OR CREMATORY IOOF		22d. LOCATION (City, town, or county) (State) Berlin, Somerset Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Maryland		24a. REC'D BY REGISTRAR OCT 13 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CONFIDENTIAL ON FILE

11/15/54

MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

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99. [Illegible]

100. [Illegible]



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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11435 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11420											
1. PLACE OF DEATH a. COUNTY Garrett						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman						b. COUNTY Garrett					
c. LENGTH OF STAY in 1b Minutes						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, X					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Mi. West in Woods along Rt. #50						d. STREET ADDRESS Loch Lynn					
3. NAME OF DECEASED (Type or print) First Middle Last James Russell Walters						4. DATE OF DEATH Month Day Year October 7, 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines				11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Walters						14. MOTHER'S MAIDEN NAME Lula West					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 236-14-6857		17. INFORMANT Address Mrs. Bertha Harvey Mt. Lake Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420-1 Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH Mins	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-7-61											
ACTUAL SIGNATURE James H. Feaster Jr.				NAME (Type) James H. Feaster Jr., M.D.				Address (Street, city, town, or county) Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/1961		22c. NAME OF CEMETERY OR CREMATORY Pope Cemetery		22d. LOCATION (City, town, or country) (State) Gorman, Garrett Co., Md.					
23. FUNERAL DIRECTOR H.C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR OCT 13 '61		24b. REGISTRAR'S SIGNATURE Clayton S. House			

(1831)

(M)

(A)

